

# **EXHIBIT F**

Apr. 28. 2017 12:41PM

No. 7462 P. 2

<b>University of Washington Medical Centers Family and Medical Leave Certification of Health Care Provider for Personal Serious Health Condition</b>	<b>To Employee -- Please complete the following information:</b> Name: <u>MARTHA DE BRZYCKI</u> Dept.: <u>Stroke Center</u> EID: <u>853003398</u> Employee Phone: <u>206-452-9669</u> Employee email: _____	
<b>To Employee:</b> Complete the upper right corner of this page and arrange for your health care provider to complete the remainder of the form. Return the completed form as soon as possible, but no later than 15 calendar days after the date you receive it. Return it to the appropriate office indicated in the space to the right. Contact this office if you believe that you will not be able to return the completed form within the specified time period.	<input checked="" type="checkbox"/> <b>Harborview Medical Center</b> Human Resources Operations Office 325 Ninth Avenue Box 359715 Seattle, WA 98104- 2499 Phone: (206) 744-9220 Fax: (206) 744-9955 Or, send scan to: HMCFMLA@uw.edu	<input type="checkbox"/> <b>UW Medical Center</b> Human Resources Operations Office 1959 NE Pacific Room 8B150, Box 356054 Seattle, WA 98195 Phone: (206) 598-6116 Fax: (206) 598-4610 Or, send scan to: UWMCFMLA@uw.edu
<b>Medical Facts -- TO BE COMPLETED BY HEALTH CARE PROVIDER</b>		
<b>Our employee is requesting leave from work and/or a modified work schedule under the FMLA for a health condition. Please provide the information requested below so that we can process our employee's leave request. Only provide information regarding the condition(s) that relate to our employee's request to take leave or adopt a modified work schedule.</b>		
<i>The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.</i>		
Describe the medical facts related to the condition(s) that require our employee to be off work and/or to work a reduced or intermittent work schedule (medical facts may include symptoms, diagnosis, or any plan for continuing treatment or therapy): <u>PT is having increased anxiety with panic attacks and elevated blood pressure associated with work. She needs 8 weeks off of work to reduce stress. The anxiety is affecting her work, sleep, blood pressure and quality of life.</u>		
Was your patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, dates of admission: <u>N/A</u>		
Date(s) you treated patient for this condition: <u>4/26/2017</u>		
Will your patient need to have treatment visits at least twice per year due to the condition? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
Was medication, other than over-the-counter medication, prescribed? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>RECEIVED</u>		
Was your patient referred to other health care provider(s) for evaluation or treatment? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>APR 28 2017</u>		
If yes, describe the nature and expected duration of the treatments: <div style="text-align: right;">HMC HUMAN RESOURCES</div>		
<b>For Pregnancy-Related Incapacity</b>		
Expected date of delivery: _____	Expected dates of your patient's physical incapacity due to pregnancy and delivery (not parental leave): _____	
Planned C-Section? Yes <input type="checkbox"/> No <input type="checkbox"/>	From (date): _____ to (date): _____	

Rev 3/2016



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**Need for Leave or Work Schedule Adjustment**

Several of the following questions ask about the frequency or duration of a condition or treatment. We know that health conditions can vary or change over time, so please provide your best estimate in response to these questions, being as specific as you can. Using terms such as "lifetime," "unknown," or "indeterminate" may not be specific enough for us to determine leave eligibility for our employee under the Family and Medical Leave Act.

**Continuous Leave:**

Will your patient be incapacitated for a single, continuous period of time including time for treatment and recovery? Yes ☐ No ☐

If yes, estimate the beginning and ending dates for the period of incapacity:

From (date): 04-26-2017 to (date): June 01, 2017

**Intermittent Leave:**

Will the condition(s) cause episodic flare-ups that prevent your patient from performing his/her job functions? Yes ☐ No ☐

If yes, please explain:

Based upon your patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 time per 3 months, 2 days per episode)

Frequency: \_\_\_\_\_ time(s) per \_\_\_\_\_ week(s) -or- \_\_\_\_\_ month(s)

AND

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

From (date): \_\_\_\_\_ to (date): \_\_\_\_\_

**Appointments:**

Are follow-up and/or periodic treatment appointments medically-necessary for your patient? Yes ☐ No ☐

If yes, describe the anticipated treatment schedule and any treatment recovery period(s):

Pt to see counselor & continued relaxation

Will there be a need for planned medical appointments and/or absences? Yes ☐ No ☒

Frequency: \_\_\_\_\_ time(s) per \_\_\_\_\_ week(s) -or- \_\_\_\_\_ month(s)

AND

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

From (date): \_\_\_\_\_ to (date): \_\_\_\_\_

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**Reduced/Modified Work Schedule:**

Will your patient require a reduction in or modification of the amount of time worked per week due to his/her medical condition, including any time for treatment and recovery? Yes ☐ No ☐

If yes, describe the reduced or modified work schedule that you believe is medically necessary:

This work schedule needs to be in place from (date): \_\_\_\_\_ to (date): \_\_\_\_\_

**Health Care Provider Information (please complete or attach business card)**

Name (please print) Rachel Sternoff Specialty Primary Care

Business Address 400 108th Ave NE Ste 100 Phone 425-685-6850 Fax 425-685-6861  
Bellevue WA 98004

Health Care Provider Signature (required)



Date 04-26-17

Rachel Sternoff, ARNP

Overlake Medical Clinics

400 108th Ave NE Ste. 100

Bellevue WA 98004

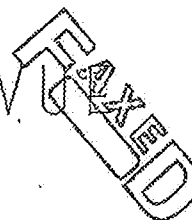


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DOWNTOWN BELLEVUE



Fax

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 Bellevue, WA 98004  
 425-635-6350 Phone  
 425-635-6351 Fax

To:	Harborview Med	Fax:	206-744-9955
From:	Adriana	Pages:	3
Phone:	425-635-6350 x 6343	Date:	04-27-2016
Re:	Marthilde Brzycki	cc:	

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